

Medicaid ACH-PCS Cost Settlement

Adult Care Home 6 Beds or Less

2006 - 2007

REPORT DUE DATE: JANUARY 31, 2008

Facility Name: _____ Facility Address: _____
County: _____ City, State, Zip Code: _____
License Number: _____ Medicaid Provider Number: _____
NPI Number: _____
FID Number: _____ Cost Reporting Period: From _____ Through _____

Line #	ITEM	AMOUNTS
1.	Total: Personal Care Service Cost	1. _____
2.	Total: Administration Cost	2. _____
3.	Total: General Services Cost	3. _____
4.	Total: Allowable Administration Cost [Line #2 minus Line #3]	4. _____
5.	Total: Facility Costs	5. _____
6.	Total: Facility Costs less Total Allowable Administration Cost [Line #5 minus line #4]	6. _____
7.	Administration Cost Factor [Divide Line #4 by Line #6]	_____
8.	Loaded PCS Costs [Multiply Line #1 by (Line #7 + 1.00)]	_____
9.	Resident Days	9. _____
10.	SA (Medicaid) Days	10. _____
11.	Medicaid % [Divide Line #10 by Line #9]	_____
12.	Medicaid Loaded PCS Cost [Multiply Line #8 by Line #11]	_____
13.	Medicaid PCS Payment	13. _____
14.	Balance Now Due: [Line #13 minus Line #12 but do not enter less than \$ 0.00]	_____

Line # Cost Report Schedule References

1.	Schedule C1, Line 20, Column 3
2.	Schedule C1, Line 120; Column 3
3.	Schedule C1, Total of Column 3; Lines 82, 105, 106, 107, 108, and 109.
5.	Schedule C1, Line 150, Column 3
9.	Schedule A, Line 19
10.	Schedule A, Line 20
13.	Schedule B, Line 4

Unpaid Owner/Operator Hours Cost Report Schedule References

List
Schedule C1, Line 20, Column 2
Schedule C1, Line 40; Column 2
Schedule C1, Line 80; Column 2
Schedule C1, Line 120; Column 2
Schedule C1, Line 140, Column 2

Signature of person filling out the form: _____

Telephone Number: _____

Date: _____

MAIL FORM AND BALANCE DUE PAYABLE TO:

Division of Medical Assistance
Finance Management-Rate Setting
2501 Mail Service Center
Attention: Elizabeth Grady
Raleigh, NC 27699-2501
Phone: (919) 855-4207